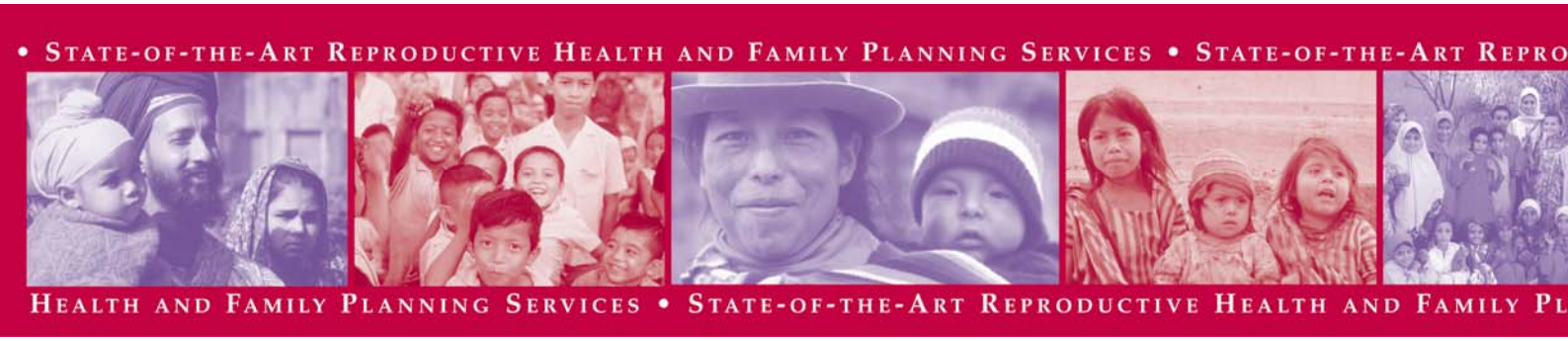
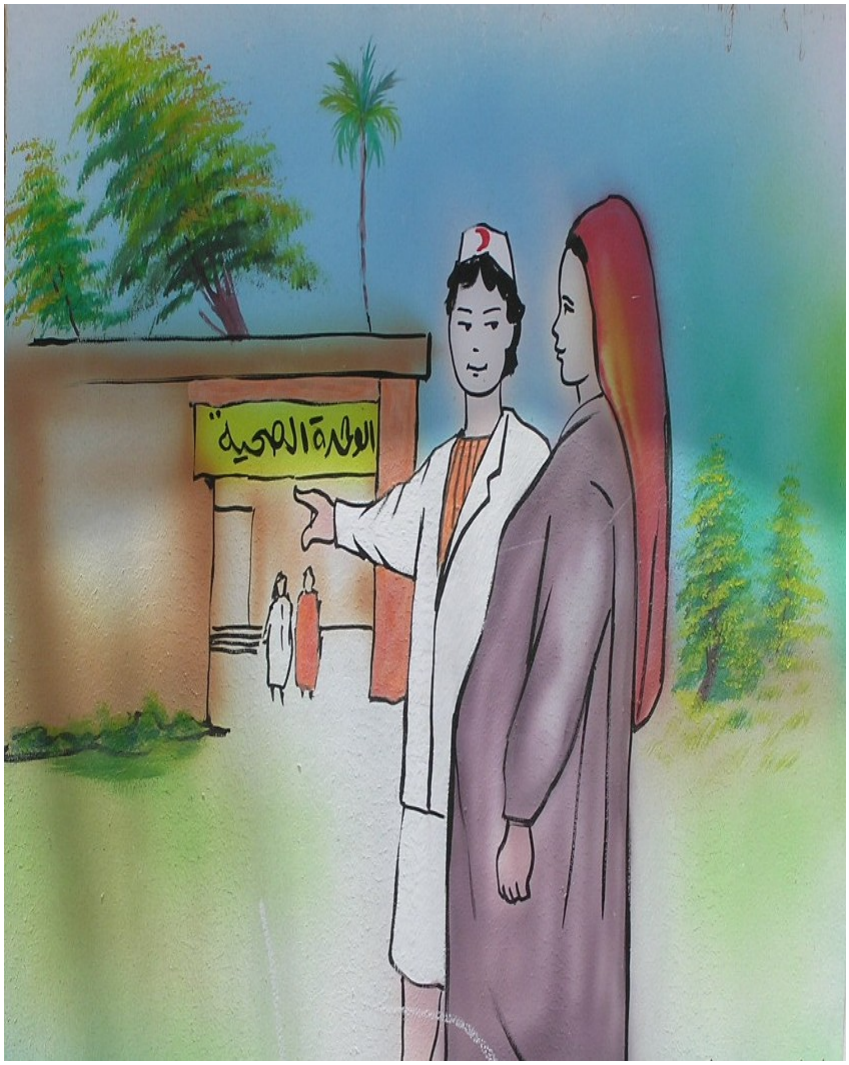


Best Practices in Egypt:

TAHSEEN Integrated Multisectoral FP model: A Movement to Enable Adoption of Healthier RH/FP Behaviors



The CATALYST Consortium is a global reproductive health and family planning activity initiated in September 2000 by the Office of Population and Reproductive Health, Bureau for Global Health of the United States Agency for International Development (USAID). The Consortium is a partnership of five organizations: Academy for Educational Development (AED), Centre for Development and Population Activities (CEDPA), Meridian Group International, Inc., Pathfinder International and PROFAMILIA/Colombia. CATALYST works in reproductive health and family planning through synergistic partnerships and state-of-the-art technical leadership. Its overall strategic objective is to increase the use of sustainable, quality reproductive health and family planning services and healthy practices through clinical and nonclinical programs.

Mission

CATALYST's mission is to improve the quality and availability of sustainable reproductive health and family planning services.

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

TAHSEEN Integrated Multifaceted and Multisectoral FP model:
A Movement to Enable Adoption of Healthier RH/FP Behaviors

I. Background

Since 1978, the U. S. Agency for International Development (USAID) has worked with the Egyptian Ministry of Health and Population (MOHP) and other partners to increase the availability and quality of reproductive health (RH) and family planning (FP) services in Egypt. These efforts have led to tangible results: Egypt's modern contraceptive prevalence rate increased from 24% to 57% between 1980 and 2003, and its total fertility rate decreased from 5.3 to 3.2 (DHS 2004). Despite these considerable advances, there is still significant need in underserved areas and among men, youth, postpartum and postabortion women, and engaged and newly married couples. As the final USAID's population project in Egypt, TAHSEEN was designed to bridge the RH/FP gap caused by geographic, social and economic inequities as well as provide services to all who want and need them.

To address the remaining challenges, the TAHSEEN project (from the Arabic phrase *tahseen sihitna bi tanzeem usritna),* which means "improving our health by planning our families", launched a multisectoral and multifaceted RH/FP project that integrated FP into reproductive health and family planning programs such as postpartum and postabortion care and linked with nonhealth activities including agriculture and education. In partnership with CATALYST Consortium, TAHSEEN (2002-09) maximized the impact of existing structures and resources by creating unprecedented coalitions of government officials, policymakers, community leaders, health care professionals, religious leaders, nongovernmental organizations (NGOs), businesses, media, and citizens.

II. Strategies

The TAHSEEN model focuses on (1) improving quality of care, (2) mobilizing the community, (3) strengthening referral systems and contributing to long-term sustainability by addressing the needs and barriers to care.

1. **Improving the quality of clinical services.** The TAHSEEN implementation strategy begins by ensuring that communities have a clean, functional, up-to-date, and inviting place in which to obtain RH/FP and Maternal and Child Health (MCH) services. Steps include:
   - **Clinic renovation.** TAHSEEN starts by fully renovating the clinic in every community in which it works. Clinics are visibly improved: they become a resource communities can be proud of and want to maintain. Because TAHSEEN mobilizes community members and resources in clinic renovation, it immediately inspires trust and lays the groundwork for future community participation.
   - **Clinical training for public sector providers.** As the clinic is renovated, clinic physicians, nurses, and lab technicians are trained in revised standards of practice, which include guidelines for providing *integrated* RH/FP and MCH services, optimal birth spacing, postabortion care, and postpartum care.
   - **Complementary training for private providers.** At the same time, TAHSEEN upgrades the RH/FP skills and knowledge of private physicians and pharmacists, NGOs, and community health workers so that all providers in the community can offer consistent information and good quality care.

- **Quality improvement.** After clinical skills are upgraded, TAHSEEN expands its focus by increasing the ability of clinics to continue improving quality of care. It does this by establishing quality-improvement systems at all participating clinics that involve and connect staff, supervisors, and community members. Specifically, this system integrates and rationalizes district-level supervision of clinics; redefines roles so that supervisors act not just as inspectors but as facilitators and supporters; and gives stakeholders at the community, clinic, and supervisory levels the tools, skills, and motivation they need to constantly monitor and improve performance.
- **Reactivation of Clinic Boards and Service Improvement Funds.** Quality-improvement training and system-building is followed by the activation of long-dormant Clinic Boards, which are composed of both clinic staff and community representatives. Boards link clinics to communities, by monitoring clinic quality, educating community members about clinic activities, mobilizing community resources in support of clinics, and giving communities a voice on how their clinics are managed. Once boards are reestablished, members are trained using the same quality-improvement method that is used to train clinic staff. Among other things, they learn to manage their Service Improvement Fund, which collects clinic revenue and disburses it for clinic-improvement projects. Because clinic training precedes the reactivation of Clinic Boards, clinic staffs understand the value of the boards and are prepared to fully welcome them.

2. **Mobilizing the community to improve its own RH/FP knowledge, services, behaviors, and outcomes.** As quality of care improves, TAHSEEN begins to mobilize community leaders, religious leaders, youth, men, media, literacy facilitators, agriculture and irrigation extension workers, NGOs, outreach workers, theater groups, artists, and others to (1) widely and consistently disseminate TAHSEEN messages about healthier behaviors; (2) begin the process of changing community norms to support behavior change; and (3) mobilize community interest in both using and supporting clinics. Typically, TAHSEEN begins this work by acquainting leaders and community members with the health benefits of *optimal birth spacing*, and the risks associated with nonoptimal birth spacing. Communities and policymakers have responded with great enthusiasm to these efforts: they appreciate how birth spacing can protect the health of women and children. This enthusiasm has allowed for unprecedented openness and dialogue about RH/FP at community forums, between couples, and between parents and children.

   Once TAHSEEN achieves community support and confidence as a result of early mobilization and clinic-improvement activities, it introduces a second round of behavior change addressing more sensitive topics, such as postabortion care, RH/FP education for youth, and gender-based violence.

3. **Contributing to Long-term Sustainability.**
   Essential components of the Project's effort to contribute to sustainability include:
   - Institutionalizing preservice training for newly appointed doctors—integrated standards of practice
   - Redesigning the governorate-level supervisory system
   - Establishing governorate-level sustainability committees
   - Increasing the role of NGOs and the private sector in RH/FP outreach and service provision
   - Reactivating Clinic Boards with significant community participation

- Reactivating clinics' Service Improvement Funds
- Mobilizing corporate and private sectors for financial support
- Mobilizing community members to provide in-kind and small financial contributions
- Securing significant political support

To ensure that behavior change and service improvements achieved at the local level are supported and can be sustained in the long-term, the model also involves capacity-building, systems-improvement, and education and mobilization work at the district, governorate, and central levels. As part of this model TAHSEEN:

- Builds strong relationships with public sector partners at the district, governorate, and central levels, and ensures that these partners have opportunities to make public their support of service improvements and behavior change.
- Assists the central MOHP to become open to, and then formalize, new productive relationships with both the NGO and the commercial sectors.
- Revises and institutionalizes national standards of practice.
- Revises national health curricula so that they include integrated FP/MCH services and address the birth spacing interval, postabortion care, and routine and emergency postpartum care. When necessary, TAHSEEN works with the MOHP to create new curricula.
- Assists both district and central MOHP with workplan development.
- Retrains district FP and MCH supervisors in both integrated supervision and support supervision, and then reorganizes supervision schedules so they are more efficient and team oriented.
- Reactivates community-managed Clinic Boards and Service Improvement Funds.
- Proposes a revised recognition system for clinic workers.
- Improves cost-recovery systems at the clinic level by encouraging clinics to take advantage of an existing policy that allows clinics to charge more for clients after hours.
- Introduces an integrated supervision and quality-improvement system.
- Works with district teams to improve integrated, district-level work planning.
- Creates a new cadre of RH/FP financial managers in all governorates.
- Assists the MOHP to forge unprecedented partnerships with other ministries, NGOs, and the commercial sector, partnerships that will help the MOHP maximize contributions to its ambitious health plans.

III. Scaling-up

The Project introduced and tested its model in five prototype communities. As the model took hold, lessons learned from the initial five communities were used to refine the model for scale-up. In each governorate, the sequence, pace, and variety of activities within the model were adapted to suit the particular needs of each governorate and target community.

As of June 2005, the model has been scaled-up to 68 communities in 6 governorates within just 18 months.

IV. Results

The model described above has created a sense of ownership at all levels, from the central ministry to the local health providers to the individual client and community members. Ordinary citizens, encouraged by leaders they trust, are taking charge of their health needs and finding solutions to those needs both individually and collectively. District supervisors and managers are institutionalizing FP/MCH integration and participating as enthusiastic team members in clinic efforts to improve quality. Governorate officials regularly demonstrate their confidence in the TAHSEEN model by publicly lauding participants and by donating funds to the Service Improvement Funds. At the national level, senior government officials are embracing change in unprecedented ways, looking to nontraditional partners to help them continue taking advantage of the momentum created.

The Best Practices documents describe many aspects of the TAHSEEN model and provide results achieved by the project.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